World Vision Relief & Development Inc.

MIDTERM EVALUATION REPORT
KOUTIALA CHILD SURVIVAL PROJECT
SIKASSO REGION, MALI

Beginning Date: October 1, 1991
Ending Date: September 30, 1994

Submitted to:

Child Survival and Health Division
Office of Private and Voluntary Cooperation
Bureau of Food and Humanitarian Assistance
1515 Wilson Boulevard
Rosslyn, VA 22209

Alpha Mahamoudou Gitteye, M.D., M.P.H.

PVO Headquarters Contact:

Milton Amayun, M.D., M.P.H.
World Vision Relief & Development Inc.
919 West Huntington Drive
Monrovia, CA 91016

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AMPPF	Association Malienne Pour la Protection Familiale (Mali's Planned Parenthood Organization)
ARI	Acute Respiratory Infection
AT	Accoucheuse Traditionelle (TBA in English)
BCG	Bacillus Calmette-Guerin-vaccine against Tuberculosis
CHW	Community Health Worker
CMDT	Compagnie Malienne de Developpement de Textiles
CSP	Child Survival Project
DIP	Detailed Implementation Plan
DPT	Diphtheria, Pertussis, Tetanus Vaccine (DTC in French)
EPI	Expanded Program for Immunization (PEV in French)
FP	Family Planning
N	Fiscal Year
HIS	Health Information Systems
IGA	Income-Generating Activity
KAP	Knowledge, Attitudes, Practices
MCH	Maternal and Child Health (SMI in French)
MOH	Ministry of Health
MTE	Midterm Evaluation
NGO	Nongovernmental Organization
OPV	Oral Polio Vaccine
ORS/ORT	Oral Rehydration Solution/Therapy (SSS in Mali)
PVO	Private Voluntary Organization
TBA	Traditional Birth Attendant (Accoucheuse Traditionelle in French)
TT	Tetanus Toxoid
USAID	United States Agency for International Development
VA	Village Association
VHC	Village Health Committee
VHV/HV	Village Health Volunteer/Health Worker
WCBA	Women of Childbearing Age
WHO	World Health Organization
WV	World Vision
WVRD	World Vision Relief and Development Inc.

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SUMMARY REPORT OF THE MIDTERM EVALUATION KOUTIALA CHILD SURVIVAL PROJECT SIKASSO REGION, MALI

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KOUTIALA CHILD SURVIVAL PROJECT
SIKASSO REGION, MALI

SUMMARY REPORT

A mid-term evaluation was carried out for World Vision's Child Survival Project In Koutiala, Mali, from September 15-22, 1993. The purpose of the mid-term evaluation was to assess progress achieved through implementation of project activities during its extension phase, make recommendations for future directions and propose strategies to overcome any constraints encountered during this assessment.

The team leader was Dr. Alpha Mohamoudou Guitteye, from the National MOH, who also authored the report. Other team members were Dr. Youssouf Konate, Regional MOH, Dr. Elise Kone, WV Mali, Dr. Daouda Coulibaly, Project Manager and Pamela Kerr from WVRD Headquarters. A feedback session was held with the Koutiala project staff in which a preliminary report of evaluation findings and recommendations was presented.

The methodology used was both quantitative, using data collected during a KAP survey at the time of the evaluation, and qualitative using interviews both in groups and individually. The survey was conducted in each of the two distinct project zones, the rural zone composed of the Arrondisement of M'Pessoba and the urban zone composed of the Commune of Koutiala. The project environment and its position in the cercle health system, the information system, project resources, management and access to health services were also reviewed during the course of the evaluation. Particular attention was paid to the training of health agents as this is the project's main strategy for reaching its health objectives.

Following the recommendation of the Detailed Implementation Plan (DIP) review committee which considered the project objectives too ambitious, they were revised in January 1993. Survey results indicate that several of the objectives have already been met. For example, one end-of-project objective is that 40% of mothers will know the importance of TT vaccination. In the survey, 54.3% of women surveyed indicated that TT vaccination is necessary to protect both mother and baby. Another end-of-project objective is that of 20% of mothers knowing the signs of dehydration. Eighty-six percent of mothers surveyed knew the signs of dehydration.

Major recommendations focus on the financial constraints which the project is now facing and include making a careful review of project expenditures and reductions to enable the project to complete its third year. Although several of the objectives have already been accomplished, the project area health situation is still precarious and education sessions are still necessary.

Other recommended areas for review include the information system, the balance between social mobilization activities and services provided, project management and supervision provided and communication approaches between animatrices and mothers.

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EXECUTIVE SUMMARY

A midterm evaluation was carried out for World Vision's Child Survival Project in Koutiala, Mali, from September 15-22, 1993. The purpose of the midterm evaluation was to assess progress achieved through implementation of project activities during its extension phase and to propose solutions and make recommendations for any constraints encountered during this assessment. Particular attention was paid to the training of project health agents, as this is the project's main strategy for reaching its health objectives.

The team leader was Dr. Alpha Mohamoudou Guitteye, from the National MOH, who also authored the report. Other team members were Dr. Youssouf Konate, Regional MOH, Dr. Elise Kone, WV Mali, Dr. Daouda Coulibaly, Project Manager, and Pamela Kerr from WVRD Headquarters- Project staff participated throughout the evaluation which provided opportunity for self-evaluation and reflection regarding the project.

The methodology used was both quantitative, using data collected during a KAP survey at the time of the evaluation, and qualitative using interviews both in groups and individually. The survey was conducted in each of the two distinct project zones, the rural zone composed of the Arrondissement of M'Pessoba and the urban zone composed of the Commune of Koutiala. The project environment and its position in the circle health system, the information system, project resources, management and access to health services were also reviewed during the course of the evaluation.

Following the recommendation of the Detailed Implementation Plan (DIP) review committee which considered the project objectives too ambitious, they were revised in January 1993. Data from the survey indicates that the project has already accomplished many of its objectives. However, it is not possible to attribute all of these accomplishments directly to the project interventions as there are other social mobilization and information activities within the project area. Community self-reliance is being successfully promoted through various income-generating activities. Funds are shared among village women as loans.

Major recommendations focus on the financial constraints which the project is now facing and include a careful review of project expenditures and reductions to enable the project to complete its third year. Although many of the objectives have already been accomplished, the project area health situation is still precarious and education sessions are still necessary.

Other recommended areas for review include the information system, the balance between social mobilization activities and services provided, project management and supervision provided, and communication approaches between animahices and mothers.

1. ACCOMPLISHMENTS

The Koutiala Child Survival Project has completed 23 months of operations of an extension/expansion phase and is scheduled for completion in September 1994. Based on a recommendation from the Detailed Implementation Plan (DIP) Review, the project objectives were revised in January 1993. The revised objectives and accomplishments according to the MTE Survey are shown in the following table:

Table 1: Accomplishments Against Objectives

OBJECTIVES	Outputs			Accomplishments MTE Survey
	FY92	FY93	FY94	FY93
I. Nutrition				
• 30% of children aged O-3 years will be weighed three times a year.	20%	25%	30%	48%
• % of mothers will start food supplementation for their children when they are 6 months old.	10%	15%	20%	100%
• 25% of mothers will know at least two Vitamin A-rich foods.	15%	20%	25%	---
• 40% of malnourished children aged O-36 months will receive Vitamin A supplementation and deworming medicine.	20%	30%	40%	51%
• 20% of lactating mothers will know the importance of eating a balanced diet.	10%	15%	20%	---
U. ORT				
• % of mothers will know the signs of dehydration.	10%	15%	20%	86%
• 30% of mothers will know the proper management of diarrhea.	15%	25%	30%	30%
• 40% of the villages will institute a weekly sanitation day.	20%	30%	40%	60%

OBJECTIVES	output,			Accomplishments MTE Survey
	FY92	FY93	FY94	FY93
III. Maternal Health				
• 80% of villages without a maternity will have at least one trained TBA.	30%	70%	80%	100%
• 60% of the matrones will be retrained in maternal health.	30%	40%	60%	56.5%
• 50% of WCBA will hear at least one message on family planning.	20%	40%	50%	48%
• 20% of adults will hear at least one message on AIDS.	10%	15%	20%	---
IV. Immunization				
• 40% of mothers will know the number of contacts needed to have a child fully immunized.	20%	30%	40%	33.3%
• 40% of mothers will know the importance of TT vaccination.	20%	30%	40%	99%
V. Malaria Prevention				
• 40% of pregnant women will receive a weekly dose of chloroquine.	20%	30%	40%	68%

Measurable inputs and outcomes are:

a. Registration of 15,521 children aged O-6 years, 9,518 of whom are O-3 years.

- Registration coverage rate for children O-6 years is 70% of the total potential beneficiary population.
- Registration coverage rate for children O-3 years is 865% of the total beneficiary population.

b. Follow-up of 1,695 malnourished children.

- The coverage rate for malnourished children O-3 years is 51.3%.

c. Weighing of 6,438 children.

- 58.5% of children O-3 years have made a first contact with the weighing services.
- Each child age O-3 years is seen more than 1 time (1,2 times).

d. 10,749 women of childbearing age (WCBA) were registered, which is 46% of the total potential beneficiary population.

e. 3,654 women have used pre-natal consultation services, a 73% usage rate.

f. 1,957 women use family planning methods, 8% of the total potential beneficiary population.

g. 5,600 women attended nutrition education sessions (24.3% of WCBA).

2. RELEVANCE TO CHILD SURVIVAL PROBLEMS

The project is situated in one circle of the third region of the Republic of Mali. Two arrondissements and the Commune of Koutiala are covered by the project. In the Central arrondissement, the Arrondissement of M'Pessoba and in the Commune of Koutiala, the project provides a variety of community health services. The project interventions are complementary to the services provided by the health center of the circle. In the Koutiala circle the socio-sanitary infrastructure is mainly created on communities' own initiative. There are 14 maternities and 12 rural dispensaries which were created and are managed by the communities.

The most frequent diseases are infections and parasites. Mortality is usually due to Acute Respiratory Infections (ARI) and malaria, the diseases targeted by EPI, diarrhea and malnutrition. An emerging public health problem is HIV/AIDS. In Koutiala, the sero-positive prevalence rate is estimated at 3-6%.

In spite of efforts made by the communities, health coverage remains low, the overall situation being characterized by: a high infant mortality rate of 102 per thousand; a low immunization coverage rate of 45 per thousand, and a low mother and child coverage in terms of health and socio-educative activities, for example: 86% of mothers do not have post-natal consultations, 40% of mothers do not know the age for measles vaccination, 53% of mothers do not know the reason for being vaccinated against tetanus and only 22% of children less than two years of age are completely vaccinated against the childhood diseases targeted by the Expanded Program on Immunization (EPI).

This overall health situation has justified the extension of the project. In its present phase, the Child Survival Project is targeting the following priority interventions: Nutrition, Oral Rehydration Therapy, Maternal/Child Care, Immunization, Control of Malaria, HIV/AIDS education and promotion of Income Generating Activities (IGA) for women.

3. PROJECT E - N E S S

As indicated in Table 1, a number of the project objectives have been surpassed. There was no data for HIV/AIDS prevention accomplishments which accounted for 10% of project resources as no baseline data on Knowledge, Attitudes, Practices (KAP) were collected and no data were collected during the midterm survey. HIV/AIDS activities to-date consist of providing financial inputs to the local Ministry of Health (MOH) awareness campaign.

Project responsibilities for immunization are through social mobilization and education among the target population and training of animatrices and Village Health Committee (VHC) members to identify incompletely vaccinated children for referral, with the MOH in charge of delivering the vaccines. The Village Health Committees are ready to mobilize for vaccination but no vaccinator comes to the villages for immunization sessions,

The provision of immunization services is a serious problem in the project area. The commitment of the MOH to ensure sustainability of immunization activities has not been consistent; therefore, the immunization strategy has not worked as planned.

4. RELEVANCE TO DEVELOPMENT

The project interventions have been particularly reinforced at the level of the rural communities through the provision of funds for income-generating activities. Each village in the rural area has been allocated an amount of 100,000 CFA (approximately $358) for a total of 6,100,000 CFA ($21,863). The management of the funds has been left to the autonomous initiative of village women's organizations.
Community self-reliance has been promoted through the various IGA activities which include gardening, salt trading, shee-butter manufacture, medicines and drugs and village loans. The funds are shared among village women as loans and each recipient is responsible for reimbursing the fund with a small amount of interest.

Women's development requires an improvement in reading and writing capacity but there are no literacy activities carried out in the project. The following table illustrates the level of instruction (education) reached by women in the target population.

Table 2:
Female Literacy/Level of Education

Level of Instruction	Urban Zone		Rural Zone		Combined Project Area	
	#	%	#	%	#	%
No level	113	41.5	171	62.2	284	51.9
Alphabetized	41	15.1	65	23.6	106	19.4
Primary						
-Cannot Read	42	15.4	20	7.3	62	11.3
-Can Read	41	15.1	6	2.2	47	8.6
Secondary	15	5.5	3	1.1	18	3.3
Other	20	7.4	10	3.6	30	5.5
Sample Size	275	100	272	100	547	100

- 51.9% of ***mothers*** in the project area have no level of instruction
- 71.3% of mothers cannot read
- Only 3% of mothers have reached the secondary level of education.

5. DESIGN AND IMPLEMENTATION

5.1. Design

The current project represents an extension/expansion of a previous CS project also funded by The United States Agency for International Development (USAID). The limitation of project coverage to two arrondissements and Koutiala commune has increased the impact of the project. All the strategies designed for the project have been adapted to the rural zone; however, the village animatrices trained in three days cannot be expected to function in the same manner as the urban area animatrices. The system of animation within the group of women called "DEMBA GNOUMAN" proved inefficient. Moreover, the urban area also has its own traditional animation structure which has not been considered in the training curriculum.

From a managerial point of view, the project has been correctly administered on the financial and objective revision side. Project management are encouraged to review the current strategies, partkularly use of human and material resources in order to accomplish all of the objectives.

5.2 Management and Use of Data

The baseline data of the project area are a combination of both qualitative and quantitative data including surveys on Knowledge, Attitudes and Practices (KAP), to better design project objectives. The approach for project objective design is pertinent. All the project objectives derive from problems identified on the field by the community and the health center.

Job descriptions exist for all personnel but are followed more for delegation of resourcea Information on productive use of. resources is not necessarily taken into consideration when decisions are made' regarding human resources.

The productivity of animatrices is not well considered in project activities in spite of the existence of an excellent data collection system. The animatrices' activity reports which are the project's main resources are not analyzed. This situation compromises the reliability of project data as activities cited in reference are produced by zone coordinators who were not planned to be the providers of services to communities in the design. Data analysis is carried out but feedback is not given to either coordinating agents or communities.

The project has not improved the Health Information System (HIS) which was already in place. There is a registration of project mother and child health activities by both the project and the health center which can create a duplication of activities. In spite of all these difficultics, the projecthas correctly produced its quarterly reports and followed its activity plans.

5.3 Community Education and Social Promotion

There is a question about the balance between social mobilization and service demand. In the project extension there is no real link between the two. For example, the project has supported immunization adivities of the MOH and is committed to social mobilization for immunization effectiveness. The absence of immunization activities on the field has produced a negative effect on promotion activities. In effect, the social mobilization action messages are perfectly designed but there are no immunization services currently provided.

There is no written guide for area coordinators. Each coordinator provides services according to his/her own qualifications. The communication between animatrices and mothers is not all that consistent, even though a particular communication approach was designed for the project. In each village, the animatrices are organized around an older one who takes the role of leader. This communication approach has developed a group memory, but the various information shared during training is not always remembered by the animatrices who are mostly illiterate (see Table 2) and over SO years of age. This communication approach remains the sole way in which the project ensures that. information is disseminated to women and communities.

In the villages, every animatrice uses a flip chart and the project ensures that the images are well understood by animatrices but has not ensured their capacity to use these images for communication with village. women.

5.4 Human Resources for Child Survival

Staffing

The Koutiala CSP has a total of 10 paid staff consisting of:

1. A Medical Doctor as project manager is responsible for project planning, follow-up, and implementation.

2. A project administrator who helps the manager in administrative, personnel, daily financial management and collaboration with local authorities.

3. Three activities coordinators for ORT and immunization promotion, maternal and child health activities, and nutrition activities, respectively.

4. A secretary based in Bamako who is used both by the project and the World Vision Office of Bamako.

5. An accountant who assists the manager in financial management and is located in Bamako.

6. Two drivers, one of whom also performs secretarial tasks in the project office in Koutiala.

7. A watchman.

Staffing is adequate enough to meet the technical, managerial and operational needs of the project. There is duplication of responsibilities between the accountant who is based in Bamako and the Administrator; between the Bamako secretary and the driver-secretary; and between the various coordinators In fact, the manager performs a number of secretarial tasks such as data entry.

Training

Training of village health agents is the main strategy for the accomplishment of project objectives and the project has placed a great deal of emphasis on training activities.

a *Training for Village Health Agents:*

- Seventeen traditional birth attendants have completed 15 days of training in recognition of the various signs of pregnancy, detection and referral of, at-risk pregnancies; nutrition counseling; normal antenatal surveillance; recognition and referral of complications of pregnancy, normal delivery-perform delivery in a dean setting with sterilized equipment; use of a sterilized blade to cut the umbilical cord; care of mothers and newborns; and promotion of maternal/child nutrition and family planning.

- Seventy village anirnatrices were trained in: maintaining contact between health services and population; identifying locally available nourishing foods; knowledge of the various food groups; how to prepare nutritious recipes for malnourished children; how to measure the arm circumference, participate in the weighing of children; follow-up of malnourished children; promotion of immunization; family planning; oral rehydration therapy and surveillance of pregnant women and referral of at-risk pregnancies. The most common activities of the animatrices are:

  Nutrition demonstrations (the best known activity which gives its name to the group of animatrices). They are designated as "the owners of the infant porridge".
  The measurement of arm circumference.
  Animation of women for income-generating activities.

b. ***Staff Training/Refresher Tminhg:***

The three area coordinators, the project administrator and the project manager have benefited from training workshops in group communication, design and follow-up, rapid appraisal in a **rural** area and acute respiratory infections.

c. ***Training for Support Structure (Collaborative) Personnel has been provided for***

- Five midwives
- Five nurses (with state diplomas)
- Ten nurses-medical chefs de **poste**
- Two medical practitioners

Provision of training in **IEC activities** for **these** professional staff has been carried out as part of the **collaboration between the project** and **local** institutions to ensure effective implementation of field activities.

d. ***Refresher Training:***

Thirteen matrones, 18 aide-soignants (first-aid **attendants),** 87 traditional **birth** attendants and 545 village **animatrices** received refresher training. Note that among these **community-based** personnel, only the **village** animatrices are directly involved in project activities and **their refresher** training is done on a continuing **basis.** The remaining community **personnel** are **affiliated** with the health system which is under the **direction** of the **Médecin Chef** of the **circle.**

5 5 Supplies and Materials for Local **Staff** .

Flip charts have been provided to **each** of the **animatrices** for use in their education sessions with village women; **Animatrices** have also been provided with a pictorial book in which to record their activities

5.6 Quality

Local project staff have the **technical** k&ledge **and skills to** cany out their current **child survival** responsiiilities. **Some** review is suggested in this area; for example, the' project manager could reassign the secretarial tasks he has assumed which would provide time for more extensive field visik and supervision of the project coordinators.

5.7 Supervision and Monitoring

The project intervention area covers 61 villages and Koutiala town. This area is divided among three zones, each of which is assigned to one of the three project coordinators. The project coordinators are ezpected to involve the nurse in charge of the subdistrict when possible. The project encourages the first-aid attendants and matrones to train and supervise the work of the animatrices. The project has developed a supervisory form document which is filled out during community visits. These forms are not used to assess the skills of CHWs but rather the health activities accomplished by the community.

The project coordinators are supervised in turn by the project manager for technical input necessary in community meetings. The monitoring of project activities is being done through quarterly data collection and analysis, although the project experienced some constraints in getting reports on time from the CHWs. The project designed a community-based health information system which was not used for monitoring purposes.

5 8 *Use* of Central Funding

AID. has provided WVRD with a total of $250,862 in headquarters funding for administrative monitoring and technical support of siz CSPs, including the one in Mali. These funds support the following key activities:

- Preparation and submission of quarterly narrative and financial reports to USAID Washington
- Fund-raising for the $131,606 WV match (29% of the total budget of $450,678).
- Preparation and submission of contracts for con&ants.
- Travel arrangements and/or orientation for project staff attending international conferences and workshops.
- Provision of feedback on tech&al reports from project staff and clarification 'of financial, legal, and tech&al issues related to project implementation.
- Distribution of tech&al articles *on CS issues*

In addition to the ongoing communication between the project management and WVRD, two visits to the project have been made by WVRD headquarters staff. These trips were for the purpose of providing technical assistance and participating in the project's midterm evaluation. Headquarters staff also assisted in the editing of-the project's DIP and annual report

5.9 PVO's Use of Technical Support

In addition to the training courses attended by project staff and the technical support mentioned in 5.8, the project has made adequate use of locally available expertise in all of the areas related to the project interventions. The CMDT assisted in a training session for project staff in a methodology for teaching primary health-care and child survival interventions. The 6th Africa Regional Child Survival Workshop which was held in Mali provided assistance in sustainability and HIS.

A consultant from the World Health Organization (WHO) visited the project to review lessons learned and recommendations from the final evaluation of the previous project, examining in particular the nutrition, CDD, EPI and maternal health interventions. A resource person from the Family Health Department in Sikasso provided assistance with training curricula for a course which was given for MOH nurses.

Technical assistance for IGAs was provided by the CMDT Women in Development (WID) coordinator. The technical support sought by and provided for the project appears to have been appropriate and adequate. The project staff have a good deal of expertise in their own particular areas and efforts are made to keep their skills updated.

5.10 Assessment of Counterpart Relationships

The project acts in close collaboration with the Minis&y of Health and the CMDT. Project activities are performed in conjunction with the MOH and there is a close working relationship with the division of the MGH in Koutiala. Monthly coordination meetings are held to discuss problems and propose solutions and the project's reports are shared with the various local and regional offices of the MOH. Project staff also participate in regional planning meetings. The Malian Minister of Health has visited the project and assured the staff of his support

There has not been any exchange of money, human resources and materials. The local MOH staff has the necessary managerial and technical skills to continue project activities after the end of project funding. The newly appointed medical officer, although expressing his availability, did. not work closely with the project this year. He concentrated his efforts on the organization of health cafe delivery in the health center of Koutiala town.

The CMDT, a development agency (c&ton production), collaborates with the project in mobilizing communities for health activities They provide support for the training of animatrices and TBAs and the follow-up of IGAs. There is no financial exchange with CMDT.

The project has been collaborating with the National AIDS Control Program in the organization of public awareness campaigns in schools and public places in the area.

5.11 Referral Relationships

In the project area, the referral sites are those assigned to the nurse in the subdistrict for the first level of referral and to the health center in Koutiala town for the second level of ieferral. The referral sites are poorly equipped and have insufficient staff who have not attended any refresher training for a long time. Access to these sites is poor because of the means of emergency transportation. People use donkey carts when transportation is needed.

Financial aocess to the care provided in these sites is inadequate because of the non-availability of essential drugs. Although the project did not improve the referral system, it encourages pregnant women to go, for prenatal consultations and sick children for care to the nearest health facility. The project is not involved in the strengthening of services in the referral sites, and in the improved access of communities to referral sites.

5.12 **PVO/NGO** Networking

The Nutrition Communication **Project** (NCP) collaborates with the project Its **assistance** is in the area of training project staff to develop communication skills and the provision of educational materials.

Grouo Pivot/SE Child Survival Projects in the country are part of this group which meets to share experiences and organize workshops on child survival issues.

5.13 Budget Management

The rate of expenditures exceeds the project budget to-date. The project faces a shortfall of approximately **$50,000** for the final year of activities. Fuel and vehicle repair costs have exceeded the amount budgeted and the project is currently **taking** steps to review the remaining budget in light of this concern.

6. SUSTAINABILITY

The Koutiala Child Survival Project bases its sustainability approach on the following:

- The training of women volunteers (animatrices) and **TBAs** with the participation of village health committees. Their training is aimed at skills transfer to enable them to conduct child survival activities.

- Income-generating activities to provide incentive to the volunteers, and contribute to the financing of child **survival** activities in the village, including sharing the cost of supervision

- Reinforcement of the community **organizational structure** (village health committees).

- Promoting behavioral change among mothers to encourage them to adopt child protective practices.

The local MOH receives a supervision allowance **paid by the community. The communities** are involved in the planning of activities. Each year, through meetings with community leaders, the project coordinators give feedback on project accomplishments and weaknesses. **The** meeting ends with a plan of action for the year with the participation of leaders. **The** implementation of project activities is mostly done by the community health workers.* The **communities** see the project as effective and they are confident in their ability to run the project after the end of project. **The animatrices** in Koutiala **town** are organized in a formal association called "good mothers". **The** project is developing this **association** so that it can take over the project activities

The local MOH is involved in the project as mentioned in 5.10. The MOH sees the project as effective. The MOH designed a five-year PHC project funded by the Netherlands government. This project will cover the whole **district** including the project intervention area and will commence in 1994. Fortunately, the priority health problems to be addressed will be MCH-related.

7. RECURRENT COSTS AND COST RECOVERY MECHANISMS

The project managers have a good understanding of the necessary resources that are required for project sustainability. The recurrent costs at present are about $85,000. The project received no commitment from the government or the communities to share any cost. The project is using a small staff, all nationals, and the services of community volunteers to lower its recurrent costs. The project encouraged the communities to contribute local resources for project activities (nutritional demons&ions, for instance). The project is recovering the price for individual growth monitoring cards and the money generated will bc used at the end of the project to replenish their stock of cards. After the end of AID funding, the salaries for the project staff and the cost of fuel and vehicle maintenance will not be sustained.

8. RECOMMENDATIONS

A number of recommendations were made by the MTE team and were shared with the project staff at a debriefing meeting prior to the departure of the team. A summary of these recommendations follows:

Health Information System

- The community-based health information system requires review for more effective use in monitoring of project activities.

Role of Animatrices

- The project should review the training of animatrices, focusing particularly on their communication skills.

- The role of animatrices within the traditional village structure should be reviewed and differences between rural and urban areas of the project considered.

Sustainability

- The project should reinforce the role. of community organizations in its approach to sustainability.

Project Budget

- Budget restrictions facing the project for the last year of operations need to be reviewed. The project is already taking steps to reduce expenditure.